Lucas County Mental Health Board System Review

Final Report

Prepared by
Technical Assistance Collaborative, Inc.

March 7, 2001

Report Contents

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EXECUTIVE SUMMARY

In July of 2000, the Lucas County Mental Health Board (LCMHB) requested that the Technical Assistance Collaborative (TAC) conduct a review of the current public mental health delivery system. This review was requested by the Executive Director of the LCMHB to examine the operational capacities and capabilities of the system to assure that current resources are being maximized in keeping with the Board's responsibilities to maintain and assure effective stewardship of public mental health funding.

The purpose of TAC's review was to identify issues and provide recommendations with their corresponding benefits and risks for consideration to the LCMHB. The primarily objectives of the review included: (a) assessing the efficiency, productivity, and effectiveness of the current provider system; (b) determining if public resources are being spent most effectively; and (c) assessing the degree to which public funds are allocated in a manner to best meet priority consumer needs in Lucas County.

In this mental health system review, TAC has identified areas for improving the quality, effectiveness, and accountability of the LCMHB provider system. These will require an investment of time, commitment and resources to propel and/or compel the system to achieve the characteristics that of an "ideal" public mental health system of care. The findings and recommendations by TAC regarding the Lucas County System are framed within the context of the following criteria for an exemplary service system:

- Consumer orientation
- Clinical excellence
- Continuity of care
- Integration of services
- Stewardship of public funds
- Clearly articulated vision
- Well defined and feasible strategies
- Effective use of information and technology

- Human resources development
- Culture of quality and high expectations

TAC's recommendations address the following six categories, they include:

- Implement consumer based outcome and performance measures;
- Implement performance based contracting;
- Use outcome and performance data to decide the future service delivery roles of the current contract providers;
- Implement best practices to fill service gaps for priority consumers;
- Implement the flat fee for non-Medicaid services and explore other funding approaches; and
- Obtain new resources to promote service excellence within an exemplary public mental health system.

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I. INTRODUCTION

The Lucas County Mental Health Board, (LCMHB) engaged the Technical Assistance Collaborative (TAC) to conduct a review of the current public mental health delivery system. The review highlights both service delivery strengths and recommendations for improvement.

The LCMHB service delivery system is well developed and highly regarded nationally as well as throughout the state of Ohio. The LCMHB service delivery system includes a comprehensive array of services with over 17 provider agencies as well as adult care facility providers. Stakeholders, such as advocacy groups, private citizens, service providers, family members, consumers, and public officials are very involved, and have substantial effect on the system. Many of the consumers and families served straddle organizational boundaries and are served by multiple county-level service providers (i.e., Juvenile Justice, Alcohol, Drug and Addictions Services (ADAS), Child Welfare, Public Schools, Corrections, Health Department, etc.) that coordinate to various degrees with LCMHB services.

Despite the comprehensive nature of the system, and the strength of the LCMHB, TAC notes that some elements of the mental health delivery system are outside of the authority and control of the LCMHB. These include:

- Development of a viable alternative to the public hospital, so that savings derived from reductions in the use of state operated inpatient beds can be redirected to expand community-based options. TAC understands that there are both political and practical implications to dramatic reductions in state hospital beds which include labor issues for displaced public employees, and a convenient location for hospitalized consumers to remain in their communities during treatment with accessibility to and support of family; and
- Lack of control or input by the LCMHB concerning Medicaid-only providers. Currently, any willing provider who is approved by the Ohio Department of Mental Health may provide mental health services and receive Medicaid reimbursement. A portion of the reimbursement rate is borne by the local county government. County funds which support services rendered by Medicaid-only providers are outside of and may be inconsistent with the overall strategic and

priority planning efforts of the LCMHB; yet county dollars must be directed to fund these services.

These issues impact and play an important role in managing the overall efficiency and effectiveness of the system.

This review focused primarily on LCMHB agencies and those agencies that have or would desire greater interface with and services from the local mental health system.

The methodology used to conduct the review included interviews with key managers and employees, extensive document review, and analysis. The onsite phase of the project was conducted on July 10th to 14th; 24th to 26th; and August 14th to 16th, 2000.

During the onsite phase, TAC conducted the following interviews and site visits:

- LCMHB Executive Director and key staff;
- LCMHB Board of Directors;
- Consumer Union* Executive Director and President of Board of Trustees
- President of local AMI;
- New Connecting Points, Harbor, Rescue, Unison, and Zepf Center Executive Directors and key leadership staff; *
- Neighborhood Properties Incorporated Executive Director and staff;
- Advocates for Basic Legal Equality;
- Medicaid-only Providers (e.g. Family Service of NW Ohio, Catholic Charities);
- Consumers and family members at a consumer forum organized by the LCMHB; and
- DHS, ADAS Directors.

TAC also reviewed a substantial number of documents, including:

- Sample LCMHB provider contracts, consumer demographic data, 1999 Annual Report, 1998 Administration, Program and Service report;
- LCMHB FY 2000 Compliant and Grievance, MUI, Committee/Task Force meeting correspondence and Forensic Project Report;
- Northwest Collaborative Plan;
- Interagency agreements, contracts, and memorandums of understanding;
- Organizational Charts;
- Agency level of care criteria;
- Agency and/or program goals and objectives;
- LCMHB Medicaid compliance audits; and
- Provider agency strategic plans; discharge policies; admission and eligibility criteria; budget documents; selected statistics; intake and enrollment procedures; no-show, census, and productivity data; consumer surveys; and QA/QI plans.

* Interviews conducted on-site at the agency.

In conducting the LCMHB mental health service system review, TAC used a number of criteria derived from best practice literature and our experience in other jurisdictions. These criteria provide a template against which the system under review can be evaluated. The criteria include:

- **Consumer orientation** – respect for and responsiveness to the individual needs and choices of consumers and their families at all levels of the system. This also means including consumers and families in governance, planning, program development, quality management, and system performance evaluation;
- **Clinical excellence** – implementation of evidence-based clinical treatment practices consistently throughout the system, enforced through clinical leadership, training, standard clinical treatment protocols, and constant learning and improving through a strong and systemic quality management and quality improvement process;
- **Continuity** – assurance that every individual and family will have a single point within the system with the accountability and responsibility to be there when needed, and to respond to individual and family needs as they change over time;
- **Integration** – assurance of seamless and facilitated movement among the components of the public behavioral health system and full and coordinated access to and integration with other important services and supports, including primary health care, housing and vocational services;
- **Stewardship of public funds** – clearly identified single points of public accountability for the quality, effectiveness and efficiency of the public behavioral health system and consistent evaluations of the quality and performance of the system;
- **Vision** – clearly articulated and understood mission, values, and strategic direction for the public behavioral health system as a whole;
- **Strategy** – feasible and proven approaches to structuring, organizing, financing, and operating the public behavioral health system:
- **Technology** – the use of accurate and timely information to assure system performance and effectiveness and to continue to improve the quality and effectiveness of services.
- **Human resources** – the supply of trained, competent, and culturally relevant staff necessary to deliver best practice service models; and
- **Culture** – the expectations and beliefs by all participants in the system in the value and potential of all consumers and the value of a high quality, consumer-oriented, efficient and effective public behavioral health.

TAC will revisit these criteria in the context of TACs specific system recommendations that are discussed later in this report.

Lucas County has many strengths and has been a leader and model among mental health boards throughout the state and the nation. TAC was impressed with the dedication of staff at all levels within Lucas County who have maintained their focus on service to consumers in spite of challenges and changes in reimbursement mechanisms; mergers and consolidations; layoffs within agencies; increased demand for services; productivity, data and reporting requirements; and overall shifts in the behavioral healthcare environment. TAC

noted that consumers in Lucas County receive services in welcoming, attractive, and well maintained facilities.

Lucas County has a consumer-operated drop-in center; consumer and/or family participation on its board as well as within some provider agencies; and an active and respected Alliance for the Mentally Ill chapter with involved family and child advocates. Lucas County also has many well-established service providers who have a long and impressive history within Lucas County.

The LCMHB is fortunate to have two highly regarded and recognized providers among its service network (Rescue Mental Health Services and Neighborhood Properties Incorporated) whose services are considered best practice models in their fields and are linchpin services vital to the Lucas County service continuum. While these observations may not appear to be noteworthy achievements for Lucas County, many jurisdictions and local communities throughout the nation are yet to implement successfully and fund similar services critical to promoting hospital diversion alternatives and housing services that promote rehabilitation and recovery within the mental health system.

TAC noted much strength and expertise in the system; at least partially related to the LCMHB preparation to move into a managed behavioral health care environment through a Medicaid Managed Care Waiver. This strength and expertise includes well developed internal operational requirements for service access, established level of care criteria, internal systems for quality assurance and improvement, and the availability of data to inform managerial decision-making.

With the positive aspects of the Lucas County system noted, TAC understands that no organization is perfect. The LCMHB understands that the most effective organizations are those that know their weaknesses, have constant improvement activities in place or planned, and are not afraid to be reviewed by others. Leadership does not mean doing what is popular, but doing what is necessary. The LCMHB should be commended for exercising its public responsibility to consumers and families, taxpayers, and all Lucas County residents in the evaluation of its system.

II. AGENCY PROFILES AND STAKEHOLDER ISSUES

As noted above, TAC visited each of the adult and child serving contract agencies (Medicaid and non-Medicaid) plus Rescue Crisis and Neighborhood Properties, Inc. Each agency also prepared a substantial amount of information at TAC's request, and additional information was provided by the LCMHB. The following is a summary of our observations and discussion of issues raised by the providers.

New Connecting Points (NCP) is one of three major child and adolescent providers in the Lucas County system, serving approximately 900 children and their families. It is the only provider in the system that specializes in providing mental health services to youth. Approximately 50 percent of the agency funding comes from the LCMHB.[1] NCP provides an impressive array of outpatient mental health services for children adolescents and families. NCP provides home-based services as well as an Assistance Center which provides residential support through its foster care network, as well as a transitional living services for youth aged 17-21. The clinical philosophy supports inclusion of the entire family unit in the treatment process.

Harbor Behavioral Health is another major provider of children's services in Lucas County. Harbor also provides outpatient and community mental health services to the targeted seriously mentally ill (SMI) adult population. Harbor acknowledged that they do not serve many "deep end" adult consumers. Harbor has developed a service strategy that focuses primarily on "deep end" seriously emotionally disabled (SED) children and adolescents providing outpatient, school based, partial hospitalization, and limited CSP support capacity for the child and adolescent population.

Harbor also offers a peer-to-peer mentor program that matches 50 adult consumers to peers on an annual basis. Harbor services are provided through a network of 10 satellite locations.

Zepf Center caters primarily to the SMI adult population. Zepf has provided vocational and employment programs that have been accessible to priority consumers served by other agencies. Recent funding and contract changes have severely restricted these vocational services. Zepf also provides HUD residential housing programs serving the SMI, MI/SA and MR populations. The housing array includes supported apartments and two group homes. Zepf also provides a range of outpatient mental health services to varying degrees of intensity to meet consumer needs. One of the major concerns for Zepf during TAC's visit has been the loss of the Empact program, which provided vocational and employment opportunity to over 500 consumers. The Office of Rehabilitation Services Commission (ORSC) has restructured the program that has resulted in the phase out of this program run by Zepf, and reabsorbed the employment and vocational program into its own service operations. Zepf leadership expressed concern about the loss of this service, as this program supports some of its overhead.

Zepf has developed and purchased other business ventures to support its core operations. Zepf indicates that Merit is a workshop setting that completes piecework assignments for major corporations. Merit is not a LCMHB funded activity, however revenues generated as a result of this line of business have contributed to offsetting budget shortfalls in Zepfs' mental health services.

[1] Percentage of agency budgets supported by LCMHB funding is displayed in table on page 11.

During TAC's visit the Zepf leadership expressed concern over the potential loss of it Merit contract and the potential impact the loss of this line of business would have on the rest of its system. TAC understands that this line of business has actually been lost.

Zepf provides its clinical services through a cluster system. Zepf has seven clusters of consumers; each cluster identifies special needs of SMI consumers who require services at varying levels of intensity to accomplish the consumer's goal. Every client in the Zepf system is assigned a case manager.[2] Each cluster has a psychiatrist and vocational counselor assigned to the team. Zepf serves approximately 2500 consumer of which Zepf indicates 60 percent are Medicaid eligible; however, Zepf's 1999 revenue summary indicates that less than 20 percent of its revenues are generated through Medicaid funding. Zepf was concerned that Lucas County may have little unmet need for the SMI population left in the county. Zepf suggested that a different population was emerging. Zepf has described this "gray area" population as individuals with borderline or antisocial personality disorders with co-occurring substance abuse who may not have or be eligible for Medicaid or indigent care benefits provided through the LCMHB.

Unison is another major provider of services to the SMI and SED populations in Lucas County. Unison has a substantial array (at least 20 different programs) of services/programs which include: traditional outpatient, residential, partial hospital, services for consumers with co-occurring mental illness and substance abuse, and CSP services. Unison has found it necessary to increase its line of credit, with its associated cost to maintain services. Unison is reviewing the case management cluster model utilized by Zepf as a possible model for its CSP consumers. Unison has developed transition programs for youth up to age 22, who tend to fall through the cracks in moving from the child and adolescent service system to the adult system. Unison outreach efforts have resulted in an increased volume of referrals for services. Unison enjoys a reputation as being a preferred provider for SMI consumers.

Rescue Crisis is the freestanding access/crisis agency serving Lucas County residents. Rescue Crisis provides comprehensive services on a 24/7 basis. They provide triage, assessment, outpatient intervention (prevention/at risk assistance), and serve as hospital gatekeeper for the community.[3] They operate a 12 bed adult crisis stabilization unit (up to five days stay if necessary, admitting 120-125 persons per month). They also operate a 5 bed child and adolescent crisis stabilization unit with 35 to 40 admissions per month. Rescue collaborates and coordinates care with the consumer's primary service provider and serves as the after-hour back up for many of the major providers in the system. More than 70 percent of Rescue's budget is funded by the LCMHB. The Rescue Crisis

[2] Zepfs' case management model is different from other providers, and may add to cost of service.

[3] The NWOCP data support the effectiveness and quality of Rescue's gatekeeping function in diverting 80% of inpatient admissions to community versus state-operated inpatient facilities.

service is an expensive service with a per-capita cost of slightly over $10 for adults and children compared to similar freestanding operations operating in other jurisdictions with per-capita cost ranging from $2.00 to $10.00. While a costly service, it provides a community benefit that extends well beyond the mental health community. They serve as a vital centralized intake point for persons brought in by law enforcement, (approximately 30 percent), who are in psychiatric crisis and suspected to have mental illness.

Listed below is a summary of selected statistics for the major service providers in Lucas County.

Agency	Budget	Percentage LCMHB Funding	Average Cost Per Medicaid Client	Average Cost Per non-Medicaid	Percentage Administration and overhead[4]
NCP	$4.3m	51%	$5,452	$8,611	9% – 10%
Unison	$11m	63%	$5,013	$3,128	13%
Harbor	$8m	70%	$1,670	$699	18%
Zepf	$8.1m	64%	$5,745[5]	Not available	10%
Rescue	$4.3m	72%	$226[6] $1,034[7] $2,859[8]	Not applicable	15%

Agency	Overall compliance on a selected Medicaid audit conducted by the LCMHB	Number of Persons receiving 15K or more in outpatient MH Services
New Connecting Points	98%	68
Unison	95%	50
Harbor	92%	87
Zepf	99%	35
Rescue	95%	Not applicable

TAC visited and met with the executive leadership staff of five of the major providers, profiled above, as well as other stakeholders in the Lucas County system. While all have developed a primary service area to meet the needs of priority consumers in Lucas County, TAC noted several themes that were common to providers and stakeholders generally and to agencies specifically. This section of the report attempts to synthesize and highlight these crosscutting issues. They included the following overarching themes:

- Coordination and integration of services;

[4] These percentages may include administration and overhead that is allocated to non-LCMHB services.
[5] Includes both Medicaid and non-Medicaid.
[6] Average cost per episode of care.
[7] Average cost for stay on adult CSU.
[8] Average cost for stay on children's CSU.

- Case management;
- Rehabilitation and recovery;
- Competition versus cooperation;
- Inadequate funding;
- Duplication of services among some providers;
- High no-show rates; and
- Wait times for treatment services after the completion of the initial assessment.

Coordination and Integration of Services

Many provider agencies and stakeholders in Lucas County addressed this theme from at least two different, yet related perspectives. They included:

- Coordination and integration of services between Lucas County Departments serving the same population including special populations (i.e. MI/SA); and
- Coordination and integration of funding[9] by Lucas County among agencies serving the same population groups.

The stakeholders of Lucas County held the familiar view that greater coordination among agencies/organizations serving people with mental illness such as Juvenile Justice, Corrections, Drug and Alcohol, and the Department of Health would move the system in the right direction toward treating the "whole person" and not simply the singular condition. Stakeholders believed that such an integrated, coordinated approach would result in both improved outcomes for children, families, and adults and a more cost effective and efficient approach in service delivery.

Similarly, integration and coordination of behavioral health funding [i.e., county, state, federal (block grant); state hospital and residential dollars through a centralized entity (LCMHB and ADAS) would further maximize the benefits of the resources available. It was noted that there are entire administrative structures in place that serve many of the same consumers who may have multiple disabilities which different agencies treat separately. Resources could be maximized through such an integrated approach. The opportunity to expand the knowledge base and cross-training of treatment techniques essential for an integrated services approach among professionals, administrators, and managers, currently separated by disabilities, would in the long run make the entire system stronger. TAC believes that many of the benefits of coordination and collaboration can be achieved without combining the LCMHB with the ADAS board.

[9] Coordination and integration of funding does not necessarily mean transferred or totally controlled funding by either the LCMHB or ADAS. The coordination and integration of funding anticipated here could be accomplished through mutual agreements, multi-agency teams, etc.

Stakeholders and provider agencies look to local leadership to develop a structure that would eliminate service barriers, thus creating a flexible, seamless, integrated, clinically and culturally competent, and "unified" approach to service provision for residents in need of service in Lucas County with minimal duplication and maximum benefits for consumers. While this may be a long-term goal, TAC has attempted to focus this report and its recommendations on those system improvements that the LCMHB and its contract agencies can actually have an impact on in the short term. While combined boards may be desirable, the effort and energy to implement it would require long-term planning and serve as a distraction for system improvements that need to occur regardless of the configuration of the ADAS and LCMHB. TAC notes that many combined boards experience virtual versus true integration, meaning boards are combined in name only and that true integration at the service level rarely occurs.

Over the past year the LCMHB has made progress in addressing these issues. Those efforts include: creating an adult and juvenile task force, funding the juvenile court mental health program; and implementing the CIT program as well as the school mental health project as examples of county agency coordination.

Case Management[10]

During TAC's review, many concerns were raised related to the competencies, duties and service models of case management providers. This service component is critical because the persons performing case management activities are considered the glue that holds the treatment plan together and assures its implementation. Case managers serve as the single point of contact for most consumers and families. The views of case management were as different and varied among those entities that interfaced with case managers as well as among case management providers themselves. TAC observations related to the case management capabilities of the system can be summarized in the following broad topics: clarification of roles and responsibilities; accessibility; competencies of case management; and overlap of duties varying models of case management.

- *Clarification of roles and responsibilities* – Many consumers and advocates were unclear as to what the duties and responsibilities of case managers are. Specifically, for children and families, one key informant expressed frustration that families feel that they get the "run around" from case managers. For example, some case managers may assist and/or provide transportation assistance; while another provider's case manager will state that they are not allowed to provide transportation.
- *Accessibility* – Some of the consumers with whom TAC spoke expressed difficulty in contacting case managers or in getting phone calls returned. This was also reported in an agency consumer satisfaction survey that TAC reviewed.

[10] In spite of the concerns highlighted in this report related to case management, the North West Ohio Collaborative Plan (NWOCP) data suggest excellent case management follow-up for clients discharged from an inpatient setting receiving CSP service post discharge.

- *Competencies* – Several entities that interface with Lucas County case managers did not believe that case management services were evolving in a way to be more responsive to the complex needs of consumers meeting CSP criteria. For example, case management duties extend beyond an office and desk and that greater emphasis should be placed on working with consumers in the community versus relying on consumers to keep case management appointments in an office.
- *Overlap of Duties* – In one area of the Lucas County system, NPI has developed housing specialists to compliment case management services; however, the activities and services described by the NPI housing specialist appear to have significant overlap or resemblance with typical case management service responsibilities. The housing specialist also requested authority to refer consumers in NPI housing directly to other services such as Aim High, New Horizons, or Consumers Union; however, it is their understanding that they are currently unable to make such referrals directly without the involvement and approval of the consumer's case manager.
- *Varying Models of Case Management* – One key informant suggested that individual provider agencies should not have the discretion or flexibility to decide what its case managers will and won't do, but rather case management should be uniform and consistently implemented within all agencies. This could potentially reduce the confusion in the larger community concerning case management roles and responsibilities. TAC noted a philosophical difference within CSP agencies regarding consumers who receive case management. For example, Zepf Center utilizes the cluster system, which groups consumers with special needs into a CSP team. The clusters also include consumers who are medication-only consumers. Zepf Center has a philosophical orientation that all consumers need support, even those with the fewest needs. The other agencies do not assign case managers for medication only clients.

Rehabilitation and Recovery

Lucas County funds several rehabilitative and recovery oriented services. They include New Horizons, which provides social and recreational opportunities, and Aim High, a Club House both operated by Unison. The LCMHB also funds the Consumers Union; an independent consumer run drop-in center providing a range of peer support and mentoring services. TAC had the opportunity to visit each of these sites and hear from consumers directly regarding their experiences with the service. One point is clear; consumers have varying and different opinions about the effectiveness and quality of these services. The consumer-run drop-in center received a fair amount of criticism during the consumers' forum, and may require some technical assistance and facilitation by the LCMHB with consumers to make it a viable service option in which consumers take pride and have ownership. Lucas County should make every effort to make available a viable consumer run and operated program within its service continuum.

Also during TAC's visits, the New Horizons program was in the process of being moved into the lower level of the Aim High facility. Some consumers and staff expressed concerns related to the perceived lack of independence and autonomy that was integral to the program design that features community-based social and recreational activities. While socialization and recreational

opportunities are essential to promoting the recovery process, supporting persons with serious mental illness in accessing these activities independently with less reliance of paid staff and independent of a group of other persons with mental illness persons is an important objective. While the behavioral healthcare community articulates a basic value in individualized treatment, many of the psychosocial and clinical treatment activities do not extend beyond a group setting with non-mentally ill persons. Services provided by New Horizons, Aim High, and Consumers Union are well meaning and necessary services; however, if the central goal of integration of consumers into the larger community is not practiced, these programs can become too isolating.

Over the past decade, the concepts of rehabilitation and recovery have become common themes in planning for behavioral health services. While the effectiveness and the knowledge of rehabilitation and recovery among persons with serious mental illness are well known, the "field" has been slow to put its principles into action. This is evidenced by the lack of resources allocated toward these efforts, and the resistance among many providers and professionals to redeploying resources and changing practice patterns to implement rehabilitation techniques and recovery principles. Rehabilitation and recovery are not new services to be developed on the edge of traditional behavioral health systems. The technology and research of psychosocial rehabilitation have been known for many years, the implementation of its approaches are beginning to find fertile ground as a resource to augment and enhance the overall clinical and functional outcomes for consumers. They require a total redesign (and often re-birth) of the behavioral health system.

In spite of this knowledge, the numbers actually involved in these services and the proportion of mental health funding allocated to these activities is relatively low. The combined budget for Consumers Union, Aim High, and New Horizons is approximately $760,674, which represents only 2.3 percent of the overall LCMHB funding. According to a nationally recognized consumer consultant, on average, a benchmark of 5 percent of mental health budgets support rehabilitation and recovery oriented services. According to NPI documents, approximately 70 percent of its SMI tenants are not engaged in any psychosocial rehabilitative activity.

Zepf Center operated the Empact program that provided a range of vocational and supported employment opportunities for over 500 mentally ill consumers. TAC has learned that the Office of Rehabilitation Services Commission (ORSC) has reabsorbed this function and provides these services directly. Empact staff expressed a high degree of concern that persons with mental illness will not receive the same level of commitment and attention that is required to work successfully in choosing, getting, and keeping vocational and/or employment opportunities. It was further noted that the ORSC staff are evaluated based upon successful placement of persons with disabilities. Some respondents fear that the SMI population will be the last to receive priority attention from the ORSC

counselors who need to meet productivity targets. The LCMHB should monitor this transition closely on behalf of Empact with the Zepf Center to assure that a reduction in vocational and employment services does not occur. A diminished employment and vocational resource such as Empact will create unintended service gaps and weaken the LCMHB's rehabilitation and recovery efforts. Empact currently has a budget of $464,559. These services are too important in the overall recovery process to be lost to or reduced for consumers of the system.

Competition Versus Coordination/Cooperation

TAC noted in its review of provider agencies that many felt or believed they were in competition with other providers who are serving the same population. Most providers attributed this shift from collegial collaboration to competition as a result of the change in the reimbursement methodology from grant-based funding to fee-for-service funding. Agencies indicated that there are few opportunities for agency collaboration that would include sharing of best practices and "lessons learned" that could be shared among providers to benefit the entire system. Many agencies expressed reluctance to share information for fear that a broad dissemination of information among peers and colleagues may disadvantage a provider in a way that would result in financial consequences. Many providers believed that this competitive environment created few incentives to work together in a meaningful way.

It was also suggested that, due to competition, some providers tended to discharge consumers who may be more challenging to engage quickly, than those who are more likely to cooperate in treatment with little effort or extensive agency resources. According to the North West Ohio Collaborative Plan report (NWOCP) data "very large numbers of the clients treated in the public system are terminated from treatment without having reached the therapeutic objectives specified in the treatment plan." This sense of competition versus collaboration provides an incentive for agencies to provide a broad array of services attempting to serve most consumers needs, rather than transferring or referring consumers to other agencies that may be more expert and skilled in providing the service. TAC found that each agency has slightly different discharge criteria. It appears that discharges appear to occur consistent with policy; however, NWOCP indicates that only 15 percent of discharge dispositions are due to goals being met.

Inadequate Funding

Provider agencies suggested that the LCMHB funding was inadequate to provide the services Lucas County residents need. Whether services were provided under a grant or fee-for-service basis, provider agencies believe that the funding has not been adequate. Some agencies report that the fee-for-service mechanism has heightened the financial pressures they experience in an effort to

cover the cost of providing services. Stakeholders indicated that grant based funding was not a solution in and of itself. TAC does not endorse returning to grant-based funding without specific performance expectations for providers. [11]

In addition, some expressed concern that the Medicaid rates have remained the same for over five years. Provider agencies also expressed that the funding may be sufficient for the priority population; however they are serving consumers with significant mental health concerns that are not a part of the LCMHB priority population which the LCMHB has a legal mandate to serve, and may not be Medicaid eligible. TAC believes that the LCMHB must maintain its safety net role for high-risk priority consumers, traditionally the SED and SMI populations. It would be unfortunate to frame this issue in the context of the "LCMHB priorities" versus the "service provider priorities."

The LCMHB, with its providers, may consider the following conditions that should exist in engaging in a dialogue that addresses the "LCMHB priority population" versus "service provider priorities." First, the reallocation of funding to non-priority consumers can and should only occur when those SED and SMI consumers require fewer services.[12] Second, to reach the non-priority population with the existing funding would require greater flexibility in service delivery[13] and would rely significantly upon non-clinical supports to improve consumer outcomes. Finally, the current reimbursement structure would need to be restructured, away from fee-for-service funding to a blended, all inclusive reimbursement model which promotes and rewards providers for "doing the right thing" for consumers versus "doing only what you get reimbursed for." TAC believes that early and uncomplicated access to care, combined with effective treatment interventions that build upon natural systems of support most often found outside the treatment setting, will result in cost efficiencies and better clinical outcomes in the long run. Stated differently, LCMHB should identify providers who work with the most difficult consumers and families produce the best clinical outcomes at the lowest cost.

Duplication Among Service Providers

Duplication in services among providers caring for consumers in Lucas County was a theme that was articulated by consumers, family members, as well as agency representatives.

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[11] TAC understands that even with grant-based funding a certain number of units may be required in order to receive the full grant funding. So again, the ability to cover the cost of services is dependent upon agencies delivering a required number of units of services or serving a specific number of consumers. In some ways revenue generation and covering service costs have become the priority in measuring the effectiveness and efficiency of agency operations, versus clinical outcomes for consumers and families.

[12] Fewer services would be indicated once individuals have achieved or regained maximum independent functioning in specific aspects of their lives other than clinical treatment as measured by some objective and tested assessment tool.

[13] See section on rehabilitation and recovery.

From the consumer perspective, consumers and families preferred the option of having several providers to choose among, so that they did not feel stuck with a provider they believed was not meeting their needs. This position was certainly highlighted by the preferences articulated during the consumer forum in selection of their psychosocial services provider. Imagine if there were only one provider to choose from, and consumers felt it did not meet their needs. The consumer would have the following choices: (1) accept less than optional service; (2) go without the needed and desired service; or (3) complain until the service improved. None of these options is acceptable in a consumer oriented service system. At least in the case of more than one psychosocial service provider, consumers have another program to go to and receive service.

From the provider perspective, duplication of services among providers with its accompanying direct service and overhead costs was a concern. Many agreed that minimizing cost due to duplication would/could free up resources that could be redirected toward other needed and desired services in the system. More importantly, providers must compete with each other essentially for the same "consumers." Under the purchase of service arrangement, providers do not get paid unless they deliver a service to consumers. TAC will address this issue in another section of its report in looking at parallel capacities in the system and its consequences.

High No-Show Rates

The issue of high no-show rates is an industry phenomenon that is not unique to Lucas County. Data received from agencies and reviewed by TAC suggest that the average no-show rate across the provider system is approximately 50 percent. Consumers accessing the Lucas County service system for the first time may call Lucas County Enrollment Center (LCEC), the provider agency directly, or walk into an LCMHB agency to receive services. The LCEC is given a block of appointment times from each agency to which they assign consumers who contact LCEC directly for an intake appointment. Consumers generally receive outpatient mental health intake appointments within 72 hours. Completion of the intake (i.e., administration of a diagnostic assessment) takes place on-site at the provider agency.

Agencies justifiably are concerned with shoring up the intake process through developing a process or system that maximizes the potential of serving every potential new or returning consumer who requests, schedules, and is appropriate for services, while minimizing down-time for staff due to no-shows. Substantial agency resources are invested in the front-end of the treatment process to assess and evaluate the treatment needs of consumers. High no-show/cancellation rates can contribute to lower productivity. The LCMHB and its provider agencies should work together to improve this performance indicator. Provider agencies are exploring various remedies to reduce the incidence of no-shows. They include: overlapping appointments by some time factor to increase

productivity, reminder letters, and instituting call systems to consumers reminding them of their appointments. Providers may need to consider non-office based, non-traditional intake processes such as mobile outreach and/or open appointment clinic times, to get consumers into treatment and to reduce the no-show rate.

Wait Times for Treatment Services after the Completion of the Initial Assessment

An equally important concern that was echoed by both stakeholders and provider agencies is the wait time for clinical services after the diagnostic assessment. The concern of providers is that they may be losing consumers and families because they are unable to schedule treatment immediately or within a reasonable period of time. The wait times appear to vary depending upon the service the consumer is assessed to need, but on average to wait time between the diagnostic assessment and first clinical service is approximately 30 days. One agency indicated that for outpatient psychotherapy they have reduced the wait time down to six months! Wait times appear to be equally problematic for services that require child psychiatry as well. Whether it is 30 days or six months, stakeholders and providers both state that neither is acceptable and that consumers who are told they will have to wait 30 days or six months are less likely to return for treatment, thus contributing to no-shows post intake assessment.

Providers have developed their own internal strategies to review this issue. Providers should also review the management of its medical staff to insure maximization through utilization of medication groups, etc. TAC was unable to validate the extent to which the management efforts initiated to control and minimize the no-show rates and wait times for treatment issues have impacted on these statistics. Providers were in varying stages of data collection, implementation of corrective actions, and tracking their efforts.

III. EFFICIENCY ISSUES

The number of consumers in the community to be served by the public system is fairly finite at any point in time. Lucas County has several providers who currently "compete" to serve this population. Providers derive their consumer base from the same limited market pool. In addition, the change in reimbursement from grant funding to fee-for-service has heightened this sense of competition for consumers and families.

To look at the efficiency issues, there are several areas to address. There are several major service providers (Zepf, Unison, Harbor, and New Connecting Points) with substantial administrative structures (i.e., financial operations; information systems; staff development and training; human resources; and quality assurance/improvement, etc.) which support the clinical work and

services provided to consumers. Overall the LCMHB contracts with approximately 17 providers, which places LCMHB fifth among the eleven of the MetNet Boards, with 1.2 providers more than the average of all MetNet providers. MetNet is an organization made up of 11 of Ohio's mental health boards of which Lucas County is a member. Zepf, Unison, and Harbor all serve the SMI adult population to varying degrees utilizing an identical array of core services such as diagnostic assessments, medication services, individual and group counseling, and CSP services. These service providers are providing parallel service capacities to a finite number of consumers in the system. In most instances the LCMHB funding represents 50 percent or more of each agency's operating budgets that support these parallel capacities.

TAC defines parallel capacity as two or more entities providing exact or similar services in the same geographic area. In an environment that is now driven by fee-for-service, is supporting parallel capacity the most effective and efficient use of resources in a tax weary, levy weary community? TAC is aware of the stated financial pressures and adjustments that many agencies are enduring in performing in a fee-for-service environment. TAC suggests that even under the old grants payment mechanism the issue of parallel capacity is of equal concern. One of the key performance issues for agencies in this financial environment is volume. The up side is that agencies are marketing their services and engaging in outreach to identify and reach new consumers, perhaps in a way that grant funding did not promote. The down side is that, in a finite market, one agency's success in gaining more "market share" means that the other agencies providing similar services cannot compete on the same level and must either dramatically curtail services to remain viable or discontinue providing the service and/or identify another service niche that is important and valuable to the system. If these agencies were national operations whose consumer base was broader than Lucas County, parallel capacity would be less of an issue. In a finite service market one must really grapple with whether a community can financially support parallel capacity. The other complicating issue in resolving parallel capacity particularly for Medicaid providers, it that "any willing provider" may potentially become a Medicaid provider regardless of whether the need for the service exist or not.

What does all this mean? Can Lucas County afford to fund parallel capacity? What are the costs financially, clinically, and politically, for the LCMHB to consider to minimizing or eliminating duplication? How much should LCMHB invest in opportunities for consumer choice and healthy provider competition as opposed to provider efficiencies and economies of scale? All of the questions raised must be answered within the context of what the LCMHB can control, e.g. any willing provider can still become a Medicaid provider in any county in the state of Ohio. The current structure of mental health service delivery in Lucas County presents issues of choice for consumers in an environment of parallel capacity and competition among providers versus economies of scale and specialization among providers. TAC presents the following analysis of factors to

consider in evaluating the existing structure compared to one with specialized providers and less parallel capacity. They include the following:

Considerations for Maintaining Current Structure with Parallel Capacity		Considerations for a System of Specialized Providers and Less Parallel Capacity	
PROS	**CONS**	**PROS**	**CONS**
• Consumers have choice among service providers with whom they may have long-term relationships. • Workforce stability is maintained. • Existing consumer relationships are maintained. • Providers have a long an impressive history in the delivery system. • Status quo is maintained and heated, political battle with the potential of long lasting damage to relationships are avoided. Ultimately market forces could determine the number of providers that Lucas County should have.	• Lose opportunities for economies of scale. • All agencies remain weak and continue to struggle financially due to the finite consumer base upon which to draw. • May lose the opportunity to reinvest $500,000 to $1 million dollars in the system.[14] • Funding will always be a concern without a shift in provider performance expectations. • Providers continue to operate somewhat autonomously and independently. • Service array will not expand beyond existing capacity without the investment of new dollars. • Must secure resources to keep major agencies providers afloat.	• Fewer, yet larger and stronger providers will emerge. This may potentially present a management challenge. • Realize economies of scale. • Develop specialized expertise. • LCMHB may potentially save $500,000 to $1 million in administrative and operating costs.	• Consumers will have limited or fewer choices among providers. • Could disrupt consumer and clinician relationships. • Consumers with long-term relationships and loyalty to a particular agency may have to change agencies. • Hundreds of staff may potentially be affected. • Unsuccessful agencies would need to dispose of or find alternate uses for property. • Without careful oversight and clear performance standards, fewer providers may not guarantee treatment effectiveness or efficiency. • Would potentially require a lengthy and possibly litigious process. • LCMHB would need to develop an extensive process to determine services to be purchased and from whom. • The LCMHB may pay a high political price for eliminating a major service provider.

Based on the information available, it is difficult to endorse one structure over the other. Both strategies have an equal number of pros and cons to consider in maintaining the current structure versus reducing parallel capacity. The absence

[14] Figures are derived from estimated saving from the reduction of administration and overhead cost and benefits derived from economies of scale with fewer agencies as providers.

of objective consumer-based outcome and performance measures as well as service contractor performance standards makes it difficult to distinguish between and among the current service providers.

IV. A SYSTEM VERSUS COMPONENT PARTS

One of the recurrent comments that TAC heard during its key informant interview phase of the review was that Lucas County does not have a mental health services "system." Rather, it is perceived as a collection of component parts that are in some cases duplicative, competing, independent, and/or isolated. One of the issues TAC attempted to address in this review is whether the LCMHB care delivery structure represents a "system" of care for the priority population it is charged to serve. Does the LCMHB service system represent an integrated and seamless system of care? Or, does the LCMHB design reflect a collection of "programs" functioning independently from the whole?

Due to the frequency in which this statement was made, TAC believed it necessary to establish a foundational definition for "a system" and work from there. If in fact the Lucas County system was found to be a collection of disparate parts, this would certainly reduce effectiveness and efficiency of its operations. TAC defines a "system" as a group of interrelated, interacting, or interdependent parts/components forming a complex whole. In a true system, no one component can function without being connected to the other components. Based upon TAC's assessment and evaluation of the range of services financed through the Lucas County Mental Health Board service delivery network, TAC found evidence of a system in certain areas and independent functioning parts in others. The instances in which TAC believes evidence of a "system" exists are as follows:

- The coordination and interconnectedness of the services provided by Rescue Crisis in support of the whole comports to the system definition. The services provided by Rescue are not duplicated by other agencies. At the same time, Rescue depends on all other parts of the system to function well in order to do its job properly. Rescue serves as the centralized crisis service to support the other components of the system. Additionally, other components of the system have established agreements with Rescue to perform specific activities that they themselves do not provide to give strength and stability to an emerging system. Although Rescue is an expensive service, the benefits that it provides to all of Lucas County in crisis prevention and inpatient diversion outweighs the cost and allows it to contribute in a positive way to the overall well being of the system as well as the community. The idea of duplicating the services provided by Rescue would be both excessive and expensive; two entities providing the services provided by Rescue would not have sufficient volume to support the costs and would create confusion in the general population concerning where to transport persons suspected of mental illness who are in crisis. Furthermore, the experience and expertise of this provider in delivering this service in fact may make them more efficient because they have specialized in becoming expert in a well-defined area of the Lucas County care delivery "system." TAC understands that initially two crisis services, one for children and

the other for adults, existed. The LCMHB decided to combine these two emergency services to achieve both cost and program efficiencies through eliminating duplication (i.e., parallel capacity of cost and functions as well as fragmentation of access and crisis response). TAC also understands that some child and family advocates have voiced concerns related to 24processing children and adolescents with adults in psychiatric crisis in the same facility. It appears that Rescue has taken reasonable measures to minimize the "mixing" of these populations.

- Another example of a system in operation in Lucas County emerged in TAC's review of the service provided by Neighborhood Properties Incorporated. This housing developer provides a resource for the other components of the system to utilize. NPI has developed a specialty in this area and over time has become more efficient and expert in bringing special needs housing on line. The service is critical and vital to sustaining the rehabilitation and recovery goals for persons with serious mental illness while providing a supportive treatment environment in which clinical staff supports consumers. There are no other providers in Lucas County with the same values, mission, and vision as NPI. TAC understands that there are both adult and childrens' providers that provide residential services and staffed living environments. However, this is not the same as the service provided by NPI. There are other providers that provide some non-staffed, independent housing arrangements, none, however do this on the scale that NPI has provided during its 12 years of existence.

- The final example of a system is the services provided by Aim High, New Horizons, Consumer Union, and formerly Empact. As described and observed, these services would be considered under the general heading of psychosocial rehabilitative services. The services provided through these programs include psychosocial clubhouse services, supported employment, consumer drop-in services, and social and recreational activities. In an important way, the LCMHB psychosocial rehabilitation services are designed to assist consumers to develop skills and strengths in all the aspects of their lives other than clinical treatment. Simply stated, the intended goal for these services is to assist persons with SMI in structuring what they do for the 160 waking hours per week or so in which they are not participating in counseling, medication management, or visits with case managers. Thus, psychosocial rehabilitation is intended to address skills and strengths related to living, learning, working, loving, socializing, and otherwise participating and integrating into community life. The psychosocial services provided through the LCMHB serve to support all providers. While New Horizons and Aim High are operated by Unison, Harbor, and Zepf are free to refer consumers to this resource and do. The same was true of Empact. While operated under Zepf, both Unison and Harbor consumers are referred to and did access the program without barriers. For the most part these services are fairly distinct with minimal overlap and duplication of service efforts. The cost of overlap among these services is minimal in the context of the overall LCMHB or within the sponsoring agency budgets.

These examples of a system in operation in Lucas County are still fairly limited. TAC is not suggesting these components function perfectly; however, the intent is that they play very defined and specific roles that contribute to the overall performance and effectiveness of how services are delivered in Lucas County in an interactive and interdependent manner.

The examples of non-systems exist within the major community mental health centers (CMHCs), (Harbor, Zepf, Unison, and Connecting Points) and the parallel capacity provided by each. In many ways the CMHCs have evolved into "mini" systems that exist within the whole. The existing CMHCs have created and expand their service mix through internal horizontal integration. In reviewing the agencies and the services provided, many offer a wide range of programs which makes them less dependent on the rest of the system, thus achieving greater self-sufficiency, autonomy, and independence. The CMHCs do utilize the services that were described above as components of a system; however, in some instances the CMHCs actually provide those services as well.

Therefore if we revisit the TAC definition of "system" and apply it to the CMHCs, would their current functioning and role within Lucas County meet the definition? Are they interrelated, interdependent, and interacting component of the system? Yes and no. Yes, because they do interact and depend on other parts of the system that do not duplicate their efforts and they interact and depend on different services and components within their "own" service system. No, because to a large extent they rely minimally on other parts of the system that are outside their control and authority, thus creating additional capacity where capacity exists and may not be maximized due to a multiple number of providers delivering the same service.

The major provider agencies each have an Executive Director, Chief Financial Officer, Medical Director, Director of Quality Assurance/Improvement, Human Resources, and Information Systems, etc. These positions do not exist in isolation; many of these executive level positions are in charge of departments that employ several staff persons. Quite frankly some of the concerns raised by stakeholders and providers in calling for greater coordination and integration of services at the county agency level could equally apply to a call for greater coordination and integration of services at the provider level to eliminate administrative layers and redundancies that would result in the redirection of additional resources to consumers and families. To achieve the coordination and integration of services and resources will require stakeholders in the current system to assume different roles and relinquish turf in order to assure survival of the whole.

V. ESTIMATING LUCAS COUNTY CAPACITY

One major and central question for the assessment of the current Lucas County public mental health system is capacity. Does the Lucas County system have sufficient resources and service delivery capacity to meet the needs of the defined priority service populations (youth with serious emotional disabilities and adults with serious mental illness)? Capacity can be viewed in a number of ways, none of which are conclusive, but each provides an indicator of relative capacity to meet priority needs in the community.

One indicator of relative capacity are per capita funding levels. Based upon FY 1998 MetNet data the LCMHB total receipts calculate to $103.09 per capita annually for mental health services for adults and children. Or translated differently, in 1998 Lucas County had $103.09 to spend on each Lucas County resident for mental health services. This per capita figure is the third highest among the 11 MetNet affiliated Boards[15] and is $18.62 higher than the average of the MetNet Boards.

Another indicator of relative capacity are penetration rates. Penetration rates express the proportion of eligible or enrolled individuals that actually use mental health services in a given time period. In FY1998, the LCMHB experienced a Medicaid penetration rate of 9.04 percent. That is the third highest among MetNet boards and 1.5 percent higher than the average of all the MetNet Boards. Most jurisdictions consider a Medicaid penetration, or service utilization rate, of 8 to 10 percent to indicate that most potential users of mental health services are being reached.

A third approach is to use evidence-based prevalence data to estimate the "population demand for services, and then compare that figure to the actual number of individuals enrolled for services. TAC utilized national prevalence data provided through the Center for Mental Health Services (CMHS). CMHS estimates that nationally, 5.4 percent of the adult population has a serious mental illness (SMI). According to 1998 census data for Lucas County, there are 322,259 adults (persons aged 19 and over) in Lucas County. In addition, in 1998, Lucas County was ranked fifth among Ohio counties for its incidence of persons with schizophrenia within its population. Applying the national prevalence percentage provides an estimate of approximately 17,401 adults in Lucas County with a serious mental illness. Statistics provided by the Lucas County Mental Health Board indicates that its providers served 7,754 adults with serious mental illness in 1998. The number of SMI adults served represents 44.5 percent of the estimated adult population with serious mental illness.

TAC realizes and understands that not all 17,401 of the estimated adults with serious mental illness in Lucas County would want or accept public sector services. It is not known how many adults meet the financial eligibility criteria for access to SMI services in Lucas County. However, national figures indicate that SMI is significantly negatively related to family income, and that the prevalence of SMI is greatest among persons with less than $20,000 family income.[16] Recent studies have shown that less than 12 percent of individuals with schizophrenia or bi-polar disorder obtain employment in the competitive sector.[17] Thus, it is safe to estimate that at least one half of non-Medicaid individuals with SMI in Lucas County are unemployed or under-employed, and are likely to be medically indigent. It is also commonly understood that about 10 percent of all Medicaid

[15] The eleven MetNet Boards are the largest in Ohio in terms of both population and budget.
[16] CMHS; ***Mental Health in the United States,*** *1996*
[17] Liberman, RP and Mintz, J. ***Psychopathology and the Capacity to Work.*** 1998

enrollees typically access behavioral health services each year, and that between one third and one half of all SSI recipients (under 65) suffer from serious mental illness. TAC assumes that the adult population in Lucas County will stay relatively stable.[18] TAC believes that the number of SMI adults who are at or below 200 percent of the poverty level would provide a good approximation of the total need at any point in time for public sector services by the target population. TAC finds that approximately 30 percent of adults with SMI in Lucas County have or will avail(ed) themselves of public sector mental health services. Therefore, the number of SMI consumers that Lucas County should develop capacity to serve equals approximately 5,220 SMI adults.

These calculations are summarized in the table below:

A	Adult Population 19+ Years[19] and older	322,259
B	National Estimated Percentage of Seriously Mentally Ill from CMHS	5.4%
C	Lucas County Estimated Number of Seriously Mentally Ill in Adult Population[20]	17,401
D	Number of Consumers with Serious Mental Illness Served in FY 1999[21]	7,754[22]
E	Percentage of Seriously Mentally Ill Consumers Reached[23]	44.5%
F	Estimated Number of SMI Consumers who need Public Sector Services[24]	5,220
G	Percentage of Lucas County Estimated Need Reached[25]	149%

Applying the same calculations and methodology to the child and adolescent population in Lucas County produces the following results:

A	Children & Adolescents (C&A) Population[20] 0-18 years	126,293
B	National Estimated Percentage of SED C&A from CMHS[21]	7%
C	Lucas County Estimated Number of SED in C&A Population[22]	8,841
D	Number C&As with SED Served in FY 1999[23]	2,920[26]
E	Percentage of SED C&As Reached[24] in Lucas County	33%
F	Estimated Number of SED C&A who need Public Sector Services[25]	2,652
G	Percentage of SED C&A County Estimated Need Reached[26] in Lucas County	110%

TAC is not suggesting that this is a perfect methodology, however it is a starting point for looking at the system for planning purposes to address the issue of capacity. This methodology is used in other jurisdictions nationally in service and

[18] Based on a review of admission and discharge data from the major providers agencies, the rate of new admissions is relatively equal to the rate of discharges overall.
[19] US Census Bureau 1998 Population Estimate.
[20] Computed by multiplying population by CMHS estimate.
[21] Figure from LCMHB documents and reports.
[22] Total unduplicated clients with SMI served by Rescue, Zepf, Unison, Harbor, Connecting Points and Court Diagnostic.
[23] Computed by dividing Row D by Row C.
[24] Calculated by multiplying Lucas County figure in row C the percentage of persons having incomes at or below 200% of poverty.
[25] Calculated by dividing row D by row F.
[26] Total unduplicated youth with SED served by Harbor, Unison, Connecting Points and Rescue.

funding planning efforts. TAC is sure that there are elements that are unique to Lucas County that may shift the number of those who will access public sector services.

If one accepts this as a methodology for assessing need, the results suggest that LCMHB has exceeded the estimated need based upon national projection in serving those consumers, both SED and SMI, who will seek and accept public mental health services.

Lucas County performance in exceeding the mathematically calculated need may be due to a variety of very positive factors which are a credit to the local system, such as: (1) effective outreach including early identification and engagement; (2) on-site and liaison relationships and coordination between school systems, inpatient units, and Corrections resulting in better access to outpatient treatment; and/or (3) residents of Lucas County may experience less stigma in accessing services and do so at a higher rate than in other similar communities.

TAC concludes from this data that the current resources allocated to the LCMHB are being maximized to some extent may be stretched too thin to accommodate the actual number of SMI adults and SED children and adolescents being served, which substantially exceeds the national prevalence figures of SMI and SED in the Lucas County population. The TAC methodology suggest that Lucas County has done an admirable job in meeting the needs of its residents through the public sector beyond what is ordinarily experienced in other communities nationally. Plus, the high penetration figures noted above are consistent with Lucas County performance in achieving the third highest rate among the largest counties in Ohio and supports the number of persons served beyond the national prevalence figures.

While the per-capita figure of $103.09 is among one of the highest in Ohio, many communities develop budgets and resources based upon the national prevalence figures and then upon the portion of that figure that they expect to serve through the public system. TAC suggest that the per capita funds available per Lucas County resident was developed to serve 2652 SED children and adolescents and 5220 SMI adults based upon the best prevalence methodology available. Yet Lucas County has exceeded that projection by serving an additional 2802 SMI and SED individuals with essentially a flat budget over the past several years which will require resources to adjust for serving a population with higher than projected serious mental health needs. TAC would further suggest that the higher per-capita rate is justified and required due to actual service need and high penetration rates.

The increase in the number of persons served beyond what is customary can be attributed to many factors. They include but are not limited to:

- The change in how services are reimbursed has forced providers to be more proactive in reaching out to the priority populations and increase the number actually served beyond the estimated projections; and
- Support by Lucas County of projects that target difficult to reach populations such as those in the custody of corrections and those who are homeless as well as school based services.

While TAC concludes that the data suggest that Lucas County efforts have been effective in serving more consumers for the same investment of dollars, the efficacy of the services provided is the next frontier of service development in Lucas County that is addressed in the TAC recommendations. In spite of Lucas County successes, the system is beginning to show signs of strain that have resulted in the following:

- Providers who are feeling increased financial pressures;
- Staff turnover along with the challenges in recruiting and retaining direct care staff; and
- Overwhelmed case managers attempting to manage high caseloads of consumers with greater needs e.g. MI/SA, Elders and SED children and their families.

VI. LUCAS COUNTY MENTAL HEALTH BOARD: RECOMMENDED PRIORITIES

The Lucas County Mental Health Board has the responsibility for managing the local system of care and assuring that needed services are provided and coordinated effectively. The Lucas County Mental Health Board is expected to plan for, fund, monitor, and evaluate community mental health services delivery. Furthermore, the Board is expected to contract with the number and types of providers necessary to meet the mental health service needs of its residents.

Based upon TAC's review, the LCMHB should adopt the following priorities that would support and promote the implementation of the TAC recommendations based upon its finding, they include:

- Recruitment of a Chief Clinical Officer (COO)/Medical Director at the Board level;
- Establishment of a financial tracking early warning system to assure provider vigilance over provider financial operations and viability;
- Strengthening the Quality Assurance/Improvement Program at the Board level; and
- Expansion of LCMHB to include other leadership activities.

<u>Recruitment of a Clinical Medical Director at the Board level</u>
The LCMHB should consider hiring a Chief Clinical Officer to function as Medical Director at the board level. This position would be responsible for working with the provider agencies medical leadership in establishing uniform clinical standards and protocols that will be adopted and implemented throughout the Lucas County MH service system. TAC observed an organizational structure that lacked both a common unifying clinical philosophy toward service delivery. It

is important that a common clinical framework is developed within which services are delivered to determine the best and most effective clinical interventions for the priority population served. Currently, service providers operate as independent individual service units practicing their own treatment and service approaches. Therefore, it will be vital for LCMHB to have strong, knowledgeable clinical leadership to build upon the best approaches currently in use and extend those to the entire system. The LCMHB should identify an individual with the qualities and experience to move the system toward the development and delivery of non-traditional, evidence-based best practice service models such as those identified in the recommendations section of this report.

Strengthening the Quality Assurance/Improvement Program at the Board level

It appears that the LCMHB Quality Assurance Program is limited to Medicaid audits that verify the presence or absence of data in the clinical chart within established timeframes. Overall the QA/QI function at the Board level requires strengthening that would minimally allow for the following:

- Uniformity of the QA program across program areas;
- Use of identical quality standards for all providers;
- Implementation of consistent consumer outcome measures; and
- Standardization of review protocols based on sound and clinically competent practice guidelines and good service data.

The LCMHB, through its providers, is expected to implement care management techniques as well as quality improvement methods to monitor effectiveness and efficiency of the system. The LCMHB monitors a number of system performance domains at the system level, such as consumer satisfaction, access, and complaints and grievances, and the LCMHB providers monitor an equal number of performance areas such as utilization, appropriateness of care, cost, etc. These performance measures should be recast within the framework of standardized clinical protocols. There are additional performance areas that require an equal amount of attention from the Boards and its providers. All of the performance areas that are currently tracked are critical to inform the Board on how the system is functioning in relationship to serving consumers. What is less prevalent in the system is how all of these performance measures interact with or contribute to the improved outcomes of consumers and families who are served by the system.

This standardization and uniformity of consumer outcomes will allow for benchmarking within the system and objective comparative analysis of system performance and the efficacy of clinical approaches of service providers in improving the functioning levels of consumers. Without such measures in place, it becomes increasingly difficult to justify the cost of existing services and to gain support for additional resources to support the LCMHB services, yet implementation of such systems comes with its own upfront investment of resources. The taxpaying public insists on value for the dollars invested and simply counting the number of persons served and the perception that LCMHB

has “good programs” is not good enough. The bar has been raised for providers and the Board to demonstrate the effective of treatment approaches. Said differently, “Are consumers better off as a result of a treatment experience with the LCMHB providers than before they were treated?” TAC believes that many consumers and families are greatly assisted by the interventions of LCMHB providers as recounted in personal accounts and the high level of expressed consumer satisfaction with services. Therefore, the LCMHB must focus on consumer outcomes to further demonstrate the value of the services at the consumer level.

When the focus shifts to individual consumer outcomes, the goals are to (1) monitor individual consumer change at established intervals, (2) provide critical information to the treating clinicians on clinical change and risk factors, and (3) revise data collection methods to track consumer outcome efforts. To manage a system the size of the LCMHB requires quality data that is accurate, reliable, timely and consistent. As TAC understands it, MACSIS represented an opportunity for such a clinical management information system; however, many operational issues are being worked out in the MACSIS implementation (both the LCMHB and providers indicate that they are unable to get data from the MACSIS system).

During the interview phase of this review many respondents wanted to know what are the system, program and/or consumer outcomes that the LCMHB are concerned about. The LCMHB must develop consumer based outcome measures to review the efficacy of the treatment interventions utilized to support consumers and families. In selecting consumer outcome and performance measures, TAC recommends that a collaborative process between the Board and its providers to select and uniformly track and report results be established jointly. TAC has composed a sample list of performance measures, some of which are currently monitored at either the Board and/or provider level. They include:

DOMAIN	MEASURE
Access	• Average time from request to first face to face meeting • Average time for first service appointment • Average time for the second contact
Quality	• Percentage of all diagnoses seen in outpatient within 24 hours, 3 days, 7 days, 14 days, and 30 days of discharge
Satisfaction	• Percentage of satisfied consumers and families currently services • Percentage of satisfied consumers and families who were discharged • Percentage of consumers and families discharged who attained treatment goals
Cultural Competency	• Services available and acceptable to all racial, ethnic, gender, and religious groups and work in conjunction with natural supports • Services are available in consumer primary language, including ASL.
Utilization	• Average length of stay • Re-admission to inpatient 24 hours, seven days and 30 days

DOMAIN	MEASURE
Appropriateness	• Selection of 5-10 clinical indicators to track across the system e.g. medication appropriate to diagnosis, care coordinated with the PCP, drug and alcohol assessment, consumer meets level of care criteria, etc. • Percentage of consumers discharged from non-compliant status.
Cost	• Average cost per episode of care. • Average cost 90 days post admission.
Complaints/ Grievances	• Percentage of complaints and grievance per enrollment/census
Administrative Compliance	• Percentage claims returned due to error. • Percentage of consumers who cannot obtain service within an established time frame. • Percentage of providers who submit status reports on priority consumers.
Outcomes: Functioning and Symptoms	• The success of providers in fulfilling consumer needs identified by the consumer and family soon after admission based on a review of a random sample of treatment files. • The creative use of existing services, including mainstream community resources or the development of new resources. • Improved functioning as measured by uniform, standardized, reliability and validity tested assessment tools such as the CAFAS, Multnomah, Basis 32, ASI, Quality of Life survey, Modified GAF, Ohio Scales, etc. • Consumer satisfaction. • Family satisfaction. • Housing acquisition and retention. • Number of consumers who retain independent housing. • The number of consumers in high quality educational programs. • The number of consumer employed in competitive work. • Facilitation of access to health care. • The effective use of natural supports. • The involvement of consumers and families in planning and policymaking. • Number if consumers voluntarily or involuntarily discharged in a year. • Aggregate number of hospital bed days used. • Aggregate number of Emergency room visits or crisis response contacts. • Aggregate number of consumer nights spent in a homeless shelter. • Number of consumers remaining homeless. • Improved school performance by at least one letter grade. • Improved school attendance. • Reduced disciplinary referrals. • Aggregate number of school days lost. • Outcomes related to substance abuse abatement. • Success in admitting consumers. • Aggregate number of jail days.

Establishment of a financial tracking early warning system to assure provider vigilance over provider financial operations and viability;

In addition to measuring consumer outcomes and strengthening system-wide QM/QI activities, the LCMHB needs to develop a uniform method for tracking and evaluating provider financial information. This is necessary to assure proper use of public dollars and compliance with state and county regulations and contract terms. It is also necessary to assure that the Board will have early warning information related to provider financial viability. The LCMHB cannot afford to have one or more provider agencies get into financial trouble without adequate warning and contingency planning.

LCMHB staff should carefully analyze the annual independent audits and uniform financial statements of each provider. Factors to be reviewed include: accounts receivables and receivable write-off practices; additions to and subtractions from fund balances; days of operating reserves; debt to equity ratios; administrative cost percentages and allocation methods; and other indicators of financial viability. In addition, the LCMHB should require providers to submit quarterly financial status reports including an analysis of expenditures to revenues against budget projections, revenues by payer source, aged receivables and payables, cash flow from operations, and profit and/loss (cumulative and quarterly.) This data can be analyzed by LCMHB staff in conjunction with other information related to provider financial status and risks, including the ratio of paid to submitted claims and state hospital bed day utilization.

Expansion of LCMHB to include other leadership activities

Beyond its statutory obligations and responsibilities, the LCMHB should consider integrating and/or building upon the following activities as part of its ongoing mission and leadership role. They include:

1. **Leadership Forums** — A regular forum for key behavioral health leaders to meet, discuss, and plan for innovative changes in the county's system of care. These meetings would be opportunities to think collectively about pioneering changes in direction. The Leadership Forum could also be used as a structure for developing new leaders, including consumer leaders from within the mental health system.

2. **Training** — The LCMHB should develop and offer training programs to support the human resources development needs of the public mental health system. These training programs would include competency-based training to meet credentialing requirements, as well as training in support of new models of service delivery or concepts of rehabilitation and recovery.

3. **Information Dissemination** — The LCMHB should provide a vehicle for disseminating information about promising programs and initiatives within Lucas County or neighboring counties' mental health system as well as provider performance data. Information could be targeted to specific audiences (consumers, family members, and clinicians) or organized around specific topical areas such as employment, housing, clinical advancements, or emerging best practices.

4. **Technical Assistance** — The LCMHB should continue to develop the capacity to provide a variety of technical assistance to aid providers with critical issues in the delivery of care. The technical assistance activities could be in the form of conferences, newsletters, manuals, training, or on-site problem solving.

VII. ADDITIONAL RECOMMENDATIONS

Based upon TACs review of the LCMHB system, TAC recommends that the LCMHB consider the following additional recommendations which we believe will position Lucas County for becoming an excellent public mental health system:

1. Implement consumer based outcome and performance measures

LCMHB and consumers and families will benefit from the implementation of system-wide performance and outcome measurements for its providers. Some providers have identified their own internal outcome measurements. However, a system-wide approach is needed in order to assess the overall clinical efficacy of treatment intervention in an ongoing manner. The development of performance and outcome measures is a critical starting point upon which to build and develop a comprehensive system. The absence of such measures makes it difficult for the LCMHB to objectively document the quality, efficiency, and effectiveness of the community mental health system and its providers.

As emphasized in other sections of this report, the uniform, consistent, and reliable measurement of performance and outcomes is the strongest weapon in the armamentarium of the LCMHB. Using objective and verifiable data to drive system efficiencies and change is far more desirable and understandable to the public than any competitive marketplace process that may engender efficiencies but almost certainly will also engender consumer, family, and provider disruption.

In fact, measures of performance including consumer outcomes can become a powerful market force. Consumer, families and referral sources can base their decisions on uniform performance and outcome data and providers can compare among themselves for improved provider outcomes.

2. Implement performance based contracting

Consistent use of a common set of consumer and system outcome performance measures can be incorporated into performance based contracting (PBC.) Performance based contracting can lead to overall improvements in service effectiveness and efficiency. Performance Based Contracts would spell out in detail the minimum performance standards and desired performance targets focusing in three areas: efficiency, effectiveness and consumer outcomes. The LCMHB with its contractors could develop and identify standard measures for consumers in a program who experience good outcomes. Performance of contractors must remain at or above the established minimum standards for a specific number of indicators; otherwise, the contractor is considered a low performer.

LCMHB could also consider establishment of a small contract provider incentive pool, perhaps funded with a combination of new County levy dollars and a percentage withhold from non-Medicaid fee-for-service reimbursement rates.[27] Providers exceeding performance expectations could earn a proportionate share of this incentive pool, and would be permitted to used the incentive payments to reward high performing staff, add creative services for priority consumers, and/or invest in improved agency infrastructure.

3. Use of outcome and performance data to decide the future service delivery roles of the current contract provider

The significant problems inherent in providing services through parallel delivery systems, such as duplicative administrative cost, limited economies of scale, and competition for consumers within a fixed market, were highlighted in Section III of this report. In spite of those issues, TAC recommends that the current number of major Medicaid and Non-Medicaid contract providers in the system (i.e. Unison, Harbor, Zepf and Connecting Points) be maintained, at least for the short term. TAC takes this position primarily due to the absence of objective means to determine who are currently the best "providers." The implementation of the recommendations one and two, plus the enhanced quality Improvement and provider financial monitoring recommended under LCMHB Board Priorities will assist to distinguish between and among providers and increase effectiveness and efficiency of the system over time. Furthermore, precipitous action to reduce parallel capacity, eliminate redundant administrative and overhead costs, and achieve economies of scale could be disruptive to the system if implemented without thorough data analyses and careful planning. TAC summarized the risks and benefits of reducing the number of contract agencies in Section III of this report.

During the process of implementing quality management, financial tracking, and outcome and performance measurement, the LCMHB should continue to hold strategy meetings with the major service providers to explore ways to reduce parallel capacity that could be implemented based upon mutual agreement. This could extend to voluntary mergers or business affiliations among contract providers. If mutual agreements to derive the necessary efficiencies cannot be reached the LCMHB should explore issuing a request for proposal (RFP) for all its non-Medicaid services. This approach would give the LCMHB the option to select from among strategies proposed by bidders to improve efficiency and reduce parallel capacity in the system for non-Medicaid services. It could also stimulate creative approaches and mutual strategies among providers to be successful in the competitive procurement process.

The reduction of the number of non-Medicaid contract providers could potentially free up funding that currently supports administrative cost for reinvestment in

[27] Other jurisdictions using performance contracting and an incentive pool typically withhold three to five percent of provider funding to be earned as incentive payments.

direct services through taking advantage of the potential economies of scale. TAC estimates that at least $1 million could be saved through an RFP process that limits the number of service providers or otherwise results in a more efficient use of LCMHB resources.

4. Implement a flat fee for non-Medicaid services and explore other funding mechanisms designed to provide incentives for efficiency and effectiveness in the system

The LCMHB has already initiated conversion from cost-based Medicaid fee-for-service rates to a flat fee structure for non-Medicaid services within the public mental health system. Non-Medicaid services comprise approximately 50 percent of the total fee-for-service reimbursements in the LCMHB system. This flat fee system is intended to (a) assure that the largest number of priority consumers possible are served with these state and County levy general fund dollars; (b) provide a powerful incentive for contract providers to get as many consumers as possible enrolled in Medicaid; and (c) over time reduce the over-all costs of service provision, which will ultimately have the effect of reducing (or containing increases) in Medicaid rates.

This flat fee approach has elements of prospective rate setting, which is considered to be preferable to cost-based retrospective rate setting approaches. Retrospective cost based methods, particularly in Ohio where rates are capped at the 95th percentile, tend to drive costs and rates to the maximum. There are few incentives for efficiency in a retrospective system, since reducing costs through creative and efficient service delivery has the result of reducing rates. In addition, because rates are set individually based on each agency's costs, and because Medicaid agencies are free to provide services and Medicaid enrollees are free to select service providers, there is virtually no price competition in the system. For most providers in a retrospective system, the obvious business strategy is to increase costs as much as possible to assure that rates come out as high as possible under the 95th percentile cap.

Prospective rate setting approaches are preferred because they address how much a service should cost to deliver, not how much it has been made to cost by individual provider agencies. The prospective method gives providers incentives to reduce costs rather than to increase them, since the way to remain financially viable is to deliver services at costs below the flat fee. Further, as long as Medicaid reimburses at a cost-based rate as opposed to the flat rate, providers have incentives to get potentially eligible individuals enrolled in Medicaid. This has benefits for all concerned: providers get higher rates; individuals get good medical and pharmaceutical coverage as well as behavioral health care; and the resources of LCMHB are maximized. A unit of service paid by Medicaid costs Lucas County 40 percent of what a non-Medicaid unit of service costs, which is a compelling argument for doing as much Medicaid business as possible.

In addition to the flat fee approach, TAC has recommended establishment of a small pool of funds to be used for incentive payments for providers exceeding performance and outcome targets. As noted in the section on performance contracting, this incentive pool could be funded with a portion of new county levy dollars, or through a small withhold of non-Medicaid provider flat fee payments. In most jurisdictions incentive payments are determined for each individual provider based on the number of performance targets exceeded. In some cases, all providers receive a portion of the performance payment if system-wide performance expectations (i.e., reduced hospitalization and out-of-home placements) are achieved. Another approach used in some jurisdictions is "milestone payments." Milestone payments could be payments for achieving a defined program development target (i.e., opening of a new consumer-operated program) or for attaining consumer-specific objectives (i.e., moving from long term hospitalization to the community, moving home from a child/adolescent residential treatment program.)

TAC recognizes that LCMHB has little or no authority to implement other creative funding methods such as case rates or other flexible, risk-sharing approaches. However, we recommend that LCMHB maintain discussions among peer mental health boards and state officials to develop demonstration projects or other initiatives that could (a) make portions of the LCMHB system more efficient and effective; and (b) produce information that could be used in other jurisdictions in Ohio, or in statewide initiatives such as a new Medicaid waiver.

5. Implement best practices models to fill service gaps i.e. MI/SA population and SED children and adolescents[28]

Nationally, it is estimated that 30 percent of persons with serious mental illness have substance abuse disorder, and it is widely believed that even the 30 percent is an underestimate. Therefore, approximately 2300 of the SMI consumers served by the LCMHB are likely to have a co-occurring substance abuse disorder. Co-occurring disorders are major contributing factors in loss of housing, treatment non-compliance, emergency room use, and re-hospitalization. From these facts it can be seen that co-occurring disorders should be thought of as the rule versus the exception. Further, when mental illness and substance abuse diagnoses co-occur, they both must be treated as the primary diagnosis, not one or the other[29]. Despite knowledge of the significant prevalence of co-occurring mental illness and substance abuse disorders within the Lucas County system, there are few services and resources allocated to meet the needs of this special population. TAC is aware that Unison provides a dual recovery program

[28] The LCMHB leadership enjoys an open and constructive relationship among colleagues responsible for other county agencies and could effectively champion these and other issues that require a multi-agency response as a pilot of inter-agency coordination, collaboration, and pooled resources to effectively treat this population.

[29] TAC recommends that the LCMHB take up the challenge to integrated funding and resources with Alcohol Drug and Addictions Service (ADAS) to promote a holistic approach to serving persons with mental illness and substance abuse disabilities.

certified by Ohio Department of Alcohol, Drug and Addictions Services and Ohio Department of Mental Health for this high-risk population.

The LCMHB has identified SED children and adolescents as a priority population. Three providers in the system are the major providers of these services. Because children and adolescent issues cross multiple agencies, TAC recommends best practices models based upon integrated System of Care among multiple child-serving agencies be implemented. This System of Care model would require the participation of multiple service systems that serve children e.g. child welfare, education, health, juvenile justice, mental health, and substance abuse providers. The approach to assisting children and their families should be both child centered and family focused, with the needs of the family and child driving the type and mix of services needed. Approaches to their care must be flexibly tailored to address their unique and changing needs. Such an integrated, coordinated approach would result in both improved outcomes for children, families and adults and a more cost effective and humane approach in service delivery. The "Wraparound Milwaukee" and Child and Adolescent Service System Programs (CASSP) model, for high need children and adolescents, are cited as best practice models for replication in Lucas County in utilizing this integrated service-planning approach.

6. Secure new resources to promote service excellence

TAC recommends that there be three interrelated strategies directed at supporting the attainment of overall clinical and service excellence in Lucas County by means of new funding through local tax levy efforts. First, the LCMHB should develop a strategy to address the needs assessment and capacity issues described earlier in this report. The public will need to understand why the level of capacity currently available in the system needs to be sustained short term, and why some parallel capacity is important to consumers and families. Second, the public will need to be convinced that the best possible value is being received though the expenditure of local levy funds. This can be accomplished by the application of uniform consumer focused outcome measures, and measures of access, continuity, service appropriateness, and cost effectiveness in the community mental health system. The third strategy is to show that some new benefits will accrue to the community as a result of passing the levy in addition to maintaining the current system. TAC believes that an emphasis on new early identification, prevention, and intervention services for young children is the most important and also most popular need for new resources in Lucas County.

TAC believes that the LCMHB should pursue additional "unrestricted" resources to develop a pilot project that focuses on those consumers who currently are the heaviest users of either outpatient and/or inpatient resources. The major service providers indicate that approximately 240 consumers currently utilize more than $15,000 in outpatient mental health services. Funding a pilot project that creatively addresses consumer needs versus what a particular funding stream

will pay for, will provide valuable data on effective service approaches on a micro scale that can be used and adapted to the larger system. The funding of such a project will help the service system prepare for the philosophical service delivery shift that will be necessary when and if the State of Ohio secures its Medicaid Managed Care Waiver.

Implementation of best practice services will require Lucas County systems to *integrate* at critical points in their service systems to produce the outcomes of many best practice approaches; therefore the LCMHB may consider proposing an interdependent funding strategy that promotes integration versus "winner take all". The proposal could be crafted in such a way as to create and encourage cooperation and a "win-win" scenario for county funded services that tend to serve the same population. For example, County Commissioners would only consider levy request for new funding from ADAS only if a portion (percentage of the ADAS population that have mental health needs that require an integrated service approach) of the funding was "earmarked" for populations served by both ADAS and the LCMHB. Any new funding approved by the voting public under an ADAS or LCMHB levy would require funding or an in-kind service match by the other county agency. This approach has attractive features that encourage cooperation, integration and creativity on the part of both agencies to achieve a mutually shared service objective.

Consistency of Recommendations with Criteria of Service System Excellence

If we revisit the criteria of an excellent public mental health system presented in the introduction of this report and develop a "report card" to assess Lucas County's performance in attaining system excellence, TAC finds that the criteria elements where the Lucas County system requires further development are consistent with the overall TAC recommendations for Lucas County. As mentioned in the introduction of this report, these criteria were developed from a review of best practice literature and TACs own experience in working with public systems nationally.

The first five elements Consumer Orientation, Clinical Excellence, Continuity, Integration and Stewardship reflects characteristics that should be present of any public sector human services or mental health service system in any jurisdiction. The last five elements Vision, Strategy, Technology, Human Resources and Culture reflect the practical elements of implementing specific program model and clinical treatment best practices within an exemplary public behavioral health system, without these elements, the first five criteria cannot effectively be met.

The results are presented as follows:

LUCAS COUNTY MENTAL HEALTH BOARD							
KEY SYSTEM OBJECTIVES	**STANDARD** (KEY 1 = LOWEST SCORE; 5 = HIGHEST SCORE)	**1**	**2**	**3**	**4**	**5**	**COMMENTS**
Consumer Orientation	• Respect for and responsiveness to the individual needs and choices of consumers and their families at all levels of the system. This also includes consumers and families in governance, planning, program development, quality management, and system performance evaluation.			✓			The LCMHB has consumer and family representation on its Board. Some provider organizations have consumers and family member on the board or in advisory council capacities. Through its network of multiple service providers the LCMHB offers a range of choices among which individuals and families may seek services that is consistent with TAC's short-term recommendation 3 for the LCMHB to maintain the existing configuration of core service providers until objective criteria can be developed to reduce the number of service provider yet maintain consumer choice. Consumer choice should not be thought of as limited to a particular agency, consumer choice includes choice of case manager, physician, etc. Consumers are not directly involved in an ongoing fashion in the evaluation of the mental health system, other than completion of consumer satisfaction surveys.

KEY SYSTEM OBJECTIVES	STANDARD (KEY 1 = LOWEST SCORE; 5 = HIGHEST SCORE)	1	2	3	4	5	COMMENTS
Clinical Excellence	• Implementation of evidence-based clinical treatment practices consistently throughout the system, enforced through clinical leadership, training, standard clinical treatment protocols, and constant learning and improving through a strong and systemic quality management and quality improvement process.		✓				This is an area that requires greater development and resources to focus on consumer clinical outcomes. This public system element is addressed in two areas, recommendation 1, 4 and 6 of the TAC report as LCMHB priorities and as a recommendation to develop consumer based outcome and performance measures; however, developing clinical excellence will require clinical leadership at the Board level as highlighted in this report.
Continuity	• Assurance that every individual and family will have a single point within the system with the accountability and responsibility to be there when needed, and to respond to individual and family needs as they change over time.				✓		The Lucas County System scores well for this service system element. While they are some service gaps for special populations e.g. MI/SA; aging out youth, elders, SED and families; most consumers served by the LCMHB system have a "clinical home or point of accountability" and can receive an array of services within an agency or among agencies as their needs change. Consistency of direct care provider is a challenge particularly for case managers. Lucas does not currently have any {P} ACT models in operation. TAC recommendation 4 addresses those service gaps identified.

KEY SYSTEM OBJECTIVES	STANDARD (KEY 1 = LOWEST SCORE; 5 = HIGHEST SCORE)	1	2	3	4	5	COMMENTS
Integration	• Assures seamless and facilitated movement among the components of the public behavioral health system and full and coordinated access to and integration with other important services and supports, including, housing and vocational services.		✓				While special projects have been developed and shown effective at improving integration; greater integration with courts, schools and other human service providers e.g. is needed to address the multiple needs of adults, children, adolescents and families that extend beyond the mental health services provided by the LCMHB. Integration in this criterion refers to "vertical" integration with organizations and agencies that provide a different service e.g. primary health, chemical dependency services that are complimentary to the mental health services funded by the LCMHB services. TAC's recommendations 4, 5 and 6 attempts to address strategies that will support vertically integrated approaches.
Vision	• Clearly articulated and understood mission, values, and strategic direction for the public behavioral health system as a whole.				✓		The LCMHB does have a mission vision and value statements; however, there is some concern that the mission should be more inclusive of non-priority populations whom service providers and other county agencies believe the LCMHB should serve.

KEY SYSTEM OBJECTIVES	STANDARD (KEY 1 = LOWEST SCORE; 5 = HIGHEST SCORE)	1	2	3	4	5	COMMENTS
Stewardship of Funds	• Clearly identified single points of public accountability for the quality, effectiveness and efficiency of the public behavioral health system and consistent evaluations of the quality and performance of the system.			✓			For funding under its control and authority, the LCMHB exercises sufficient stewardship of public funds. TAC has noted that a portion of mental health dollars that support the Medicaid-only providers is outside of the control of the LCMHB. The LCMHB is audited regularly and invites independent reviews of its service system such as the current review that TAC is involved. TAC recommendation 5 for the exploration of alternative funding mechanisms and the LCMHB responsibility to seek additional funding based upon demand and needs is consistent with effective stewardship. TAC also recognizes that the LCMHB performance in this area to a large extent is driven by state ODMH policy and regulatory requirements.
Strategy	• Feasible and proven approaches to structuring, organizing, financing, and operating the public behavioral health system.			✓			TACs recommendations regarding exploration of creative alternative funding mechanisms that are within the LCMHB control to implement in combination with development and advocacy for new of resources is an area for review. Additionally, seeking maximum efficiencies in the presence of parallel capacity warrants review as well.

KEY SYSTEM OBJECTIVES	STANDARD (KEY 1 = LOWEST SCORE; 5 = HIGHEST SCORE)	1	2	3	4	5	COMMENTS
Technology	• The use of accurate and timely information to assure system performance and effectiveness and to continue to improve the quality and effectiveness of services.			✓			The state ODMH information system, which the LCMHB is required to use, has meet with mixed reviews from the LCMHB as well as service providers. The expectations of what the system was designed and promoted to deliver have not mirrored user actual experience in Lucas County. The MACSIS system is still relatively new and still in the implementation phases of its develop, therefore TAC is hopeful that many of the concerns and problems noted during this review will be resolved with time and experience with the system.
Human Resources	• The supply of trained, competent, and culturally relevant staff necessary to deliver best practice service models.			✓			The LCMHB network of service providers are not insulated from issues related to the recruitment and retention of culturally competent and caring staff. These workforce issues plague human service providers on a national scale. LCMHB service providers are at various stages of introducing staff to and implementing rehabilitation and recovery principles as well as best practice models as central, not peripheral elements of the service continuum.

KEY SYSTEM OBJECTIVES	STANDARD (KEY 1 = LOWEST SCORE; 5 = HIGHEST SCORE)	1	2	3	4	5	COMMENTS
Culture	• The expectations and beliefs by all participants in the system in the value and potential of all consumers and the value of a high quality, consumer-oriented, efficient, and effective public behavioral health.				✓		According to the LCMHB 1998 Diversity Report, Lucas County met its standards for employment of ethnically diverse staff among the over 1000 persons employed in the Lucas County Mental Health System. Cultures in this context refer to the ability to respect and honor the beliefs, attitudes and behaviors of every consumer in the system. Consumer satisfaction suggests that consumers experience a high degree of satisfaction with services. TAC's contact with service providers indicated that they are sensitive to and try to accommodate the cultural needs of consumers; however, one non-direct service agency interviewed during TAC's on-site visits indicated that language barriers and competencies of some service providers is an area for development improvement.
Overall Performance	• Based upon all these criteria in aggregate, TAC would assign an overall score of 3, which is better than most other mental health systems TAC has evaluated and reviewed over the past nine years.			✓			

VIII. CONCLUSION

This report should be considered as a document design to stimulate discussion of the recommendations and to develop strategies and solutions regarding the future role and direction for service delivery within Lucas County Mental Health system.

Specifically the issues and recommendations highlighted in this report should not be viewed as absolutes but rather serve as a starting point for ongoing, open dialogue between the LCMHB and its stakeholders. Those recommendations and issues include:

- Implementation of consumer based outcome and performance measures;
- Performance based contracting;
- Use of Outcomes and performance data to decide the future service delivery roles of the current contract;
- Implement the flat fee for non-Medicaid services and explore other funding approaches;
- Development of programmatic and financial strategies to fill service gaps for high need populations i.e. MI/SA and SED through new or reallocated funding resources; and
- Obtain new resources to promote service excellence within an exemplary public mental health system.

To implement these recommendations will require the commitment of new resources, it is unlikely that new resources will become available through ODMH; yet, there are many risks associated with securing resources through placing a new levy on the ballot in the near future that will move the LCMHB toward service excellence. Most respondents interviewed by TAC pointed to a number of factors that could support caution on this issue. These include: (a) the recent unsuccessful bid for a substance abuse levy in Lucas County; (b) the stated intention of the ADAS Board to place their levy question on the ballot again next year; (c) the need for a large new school levy in Lucas County, which could compete for the voters' attention and priorities with regard to the mental health levy; and (d) the economic environment of Lucas County and the increased financial pressures of local county government.

On the plus side, the Lucas County Mental Health Board has a strongly positive image in the community, enjoys strong support from County government and many stakeholders, and has had a flawless record of getting local tax levies for mental health passed by the electorate. In addition, there appears to be some sympathy for a new levy in the community based on a clear understanding that both state and local factors have resulted in increasingly restricted resources, or competition for resources, for priority consumers served by LCMHB and its core providers. This is most evident in the following eight areas:

1. Flat reimbursement rates from the state for the past five years;

2. Increased competition for local match resources from new providers being certified as Medicaid providers without County input or control;
3. Costs related to the conversion to fee-for-service as opposed to grant-based financing mechanisms;
4. Long waiting times for access to psychiatry and on-going services for both youth and adults;
5. Perceived inadequate resources for both adults and particularly youth and their families that do not meet the priority definitions of serious mental illness or serious emotional disabilities;
6. Consumer and family demand for continued development of new best practice community service models supporting empowerment and recovery for adults and family based systems of care for youth and their families;
7. Community, consumer, and family demands for more effort and resources committed to outreach, education, prevention and early intervention for both adults and children and their families; and
8. Lucas County performance in exceeding the national projection of SMI and SED consumers served.

Based on these factors, and on the economic realities of salary and benefit inflation and competition for employees in the local marketplace, there is no question that the Lucas County Mental Health Board needs additional resources, and that a new local tax levy is both desirable and probable as a source of these needed funds. In addition, there is ample, albeit cautious, community support for a new levy within the next few years.

The real question goes back to the initial purpose of this review of the Lucas County public mental health system, but stated in a different way:

- Can the voting public be convinced that the Lucas County Mental Health Board <u>needs</u> new local levy dollars to support children and adults with mental health needs in the community? And
- Can the voting public be convinced that the Lucas County Mental Health Board <u>deserves</u> new local levy dollars tom meet these needs?

TAC believes the answers to these two questions is <u>yes</u>, but understands that a number of the strategies outlined in this report must be convincingly implemented to assure that the voting public's support for the local public mental health system cannot be undermined.

Moving from discussion and consensus to firm decisions regarding organizational structure, functions and financing will be a challenge, However, TAC believes that the implementation of these organizational priorities, financial and service delivery recommendations will greatly aid Lucas County in attaining exemplary status as an ideal public mental health system, worthy of replication.